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Indiana Journal of Global Legal
Studies

Volume 4 | Issue 2

Article 9


Spring 1997

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Recommended Citation

Rifkin, Danielle (1997) "Midwifery: An International Legal Perspective - The Need for Universal Legal Recognition," *Indiana Journal of Global Legal Studies*: Vol. 4: Iss. 2, Article 9.

Available at: <http://www.repository.law.indiana.edu/ijgls/vol4/iss2/9>

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Midwifery: An International Perspective--The Need for Universal Legal Recognition

DANIELLE RIFKIN*

I. INTRODUCTION

The practice of midwifery worldwide is the most safe, cost-effective, and satisfying method of birth-assistance. This age-old profession embraces the non-interventionist philosophy that childbirth is a natural and normal process in which the attendant merely assists in the healthy, routine progression. The World Health Organization's (WHO) European Regional Director and expert on maternity services in industrialized countries, Marsden Wagner, gave testimony which echoed the Federal Institute of Medicine's view, as well as reemphasized WHO's long-standing policy concerning the use of midwives as appropriate and safe birth-attendants:

[C]are during normal pregnancy, birth, and following birth should be the duty of the midwife profession Midwives are trained to focus on the normalcy of pregnancy and birth, placing the needs and wishes of the mother first and avoiding intervention unless absolutely necessary Obstetricians, on the other hand, are physicians trained to focus on pathology and to intervene. When this balance does not exist . . . the surgical interventions in birth rise to levels that most experts worldwide believe to be far beyond what is necessary.¹

Despite the endorsement of WHO and its supporting statistical studies, many industrialized countries continue to prohibit the midwives' profession. Of the

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1. Caroline Hall Otis, *Midwives Still Hassled By Medical Establishment: Practitioners Battle for Recognition and Autonomy*, UTNE READER, Nov.-Dec. 1990, at 32, 34.

industrialized nations, Canada and the United States most notably maintain a version of this stance.

While the United States and Canada have embarrassingly high infant mortality rates compared to other industrialized countries, they have rejected the example of their European counterparts.² Both Sweden and the Netherlands, whose infant and maternal mortality rates are consistently among the three best in the world, employ midwives to assist during well over half of their normal births.³ The restrictive laws which deny independent legal status to midwives in the United States and Canada have hindered both the safety and the reproductive choice of birthing mothers, leaving many no option but to endure the intrusive, impersonal, and often dangerous presence of a physician at their deliveries.

This paper examines the need for legal recognition and autonomy of midwifery on a global scale. The need for global acknowledgment is evidenced by an examination of the history, comparative safety, relative cost, and laws regulating the practices of midwifery and obstetrics in the United States as compared to the European nations, principally the United Kingdom.

II. THE HISTORY AND BACKGROUND OF MIDWIFERY

The practice of midwifery has existed for centuries in most nations. Historically, "lay-midwives" or "direct-entry midwives" have learned their practice through apprenticeship training, watching generations of women before them "catch" babies. The lay-midwives of today are sophisticated women who have either had extensive apprenticeship training and/or a certification from a midwifery training program. The progression of lay-midwifery into the era of medicalization led to the development of Certified Nurse-Midwives (CNMs), registered nurses who have additional training and certification from a school of midwifery.⁴ CNMs⁵ have been practicing in the United States since 1925 when a need was recognized for maternity care among lower-income populations in urban areas.⁶

2. Chris Hafner-Eaton & Laurie Pearce, *Birth Choices, the Law and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813, 814 (1994).

3. *Id.*

4. Kerry E. Reilley, *Midwifery in America: The Need for Uniform and Modernized State Law*, 20 SUFFOLK U. L. REV. 1117, 1121 (1986).

5. For the purposes of this paper, I will be using the term "midwife" to refer to both lay-midwives and certified nurse midwives, unless otherwise explicitly stated in the text.

6. Reilley, *supra* note 4, at 1121.

Although every industrialized nation conferred essentially the same status upon midwives centuries ago, the United States and Canada have taken a sharp turn away from the recognition that the United Kingdom and most every other European nation has maintained.

A. Midwifery in the United Kingdom

Britain originally preserved a system of lay-midwifery based on group support among the women of village communities. They were regulated and disciplined by their own profession and the local clergy.⁷ The recognition and legal autonomy of British midwives grew as the government's interest in public health and welfare increased. The "Poor Law Amendment Act of 1834"⁸ strongly supported the legitimization of midwifery. The "Poor Law" recognized that poverty caused illness, that the treatment of poverty would reduce sickness, and therefore that the treatment of sickness would reduce poverty. The idea of social responsibility toward the poor lent significant support to the practice of midwifery, as midwives were willing to use their skills in these lower-income areas, where physicians often were not. In 1876 a Report to the Registrar stated that continued midwife-assisted births among the poor could reduce maternal deaths by an estimated 65 percent.⁹

British midwives gained legal attention at the turn of the 20th century when they were granted State licenses. The "Midwives' Act of 1902" brought reform, recognizing and licensing midwives through the profession's own organization--the Central Midwives' Board.¹⁰ Since the 1902 Act, British midwives have retained their legal independence from physicians for a number of reasons. The hereditary British class structure did not allow physicians to aspire to the kind of power American doctors would someday enjoy. The British medical hierarchy collapsed in the 1800s instead of gaining strength as the U.S. model did. Today British surgeons are generally referred to as "Mister" and not "Doctor" which reflects the society's less than heroic view of these salaried professionals, who are paid by the government's National Health Service. Surgeons use their hands in a trade many in Britain consider

7. See CECILIA BENOIT, *MIDWIVES IN PASSAGE* 32 (1991); JEAN DONNISON, *MIDWIVES AND MEDICAL MEN* 7 (1977).

8. This Act is also known as "Victorian Poor Law." BRIAN WATKINS, *DOCUMENTS IN HEALTH AND SOCIAL SERVICES; 1834 TO THE PRESENT DAY* 1 (1975).

9. DONNISON, *supra* note 7, at 93.

10. BENOIT, *supra* note 7, at 32.

similar to other craftsmen or handymen.¹¹ The reduced social power of physicians allowed midwives to maintain their niche in the practice of childbirth-assistance. Physicians had neither the means, nor the incentive, to drive them out.

B. Midwifery in the United States

Before the 1930s in the United States, very few women considered the assistance of any birth-attendant other than a midwife. In 1916, only 19.1 percent of all births in Manhattan took place in hospitals.¹² In the less populated areas, such as Maryland outside of Baltimore, only 2.6 percent of births in 1921 occurred in hospitals.¹³ As the medical profession gained prominence, physicians began to view both lay-midwives and nurse-midwives as subordinates.¹⁴ Many nurse-midwives found themselves relegated to the role of serving rural and urban poor populations during the 1920s and 1930s. The programs and schools which were intended to train nurse-midwives to fully assist at normal births taught them to accept this role of the inferior practitioner and serve the lower-income families doctors did not wish to attend.¹⁵

The medical profession at that time was generally dismissive of obstetrics as an area of specialty. One professor of medicine stated, "the obstetrician need only be a man-midwife who is content to eat the crumbs that fall from the rich man's table."¹⁶ Opposition to the midwife resulted largely from the personal beliefs of physicians who felt a need to upgrade the status of obstetrics.¹⁷ Physicians in the United States launched a campaign through social and political pressure to convince the public, the lawmakers, as well as the medical profession that obstetrics was a sophisticated practice that required

11. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 6 (1982).

12. JUDY LITOFF, *AMERICAN MIDWIVES 1860 TO THE PRESENT* 72 (1978).

13. *Id.*

14. Beth Rushing, *Ideology in the Reemergence of North American Midwifery*, 20 *WORK AND OCCUPATION* 46, 49 (1993) (citing C.L. Buxton, *American Obstetrics Needs Nurse Midwives*, 12 *OBSTETRICS AND GYNECOLOGY* 242-45 (1958); L. Hellman, *Nurse Midwifery: Fifteen Years*, 16 *BULL. AM. C. NURSE MIDWIVES* 71-79 (1971)).

15. *Id.* (citing M. Breckinridge, *The Nurse Midwife--A Pioneer*, 17 *AM. J. PUB. HEALTH* 1147-51 (1927); H. Hemschemeyer, *Midwifery in the United States*, 39 *AM. J. NURSING* 1181-87 (1937)).

16. LITOFF, *supra* note 12, at 66 (quoting J. Whitridge Williams, *The Midwife Problem and Medical Education in the United States*, 2 *TRANSACTIONS AM. ASS'N STUDY AND PREVENTION OF INFANT MORTALITY* 184-88 (1911)).

17. *Id.* at 64.

a medical degree and should be the prevailing standard of care for all birthing women.¹⁸ Physicians began adding midwifery to their practice of obstetrics by promoting the need for medical instrumentation to increase safety in childbirth.¹⁹ Although the natural state of labor and delivery had not changed, the obstetrician began to characterize child birth as having "imposing pathological dignity,"²⁰ which in turn would require the assistance of an obstetrician.

Physicians' efforts to bolster the status of the obstetrician were rewarded with the establishment of the American Board of Obstetrics and Gynecology in 1930. Although the practices of obstetrics and gynecology had achieved their positions as specialties, the U.S. anti-midwife movement would not be abandoned until physicians were able to attain the financial status of their peers. Many obstetricians complained they were paid poorly for their services because midwives continued to attend 50 percent of births and charged less than one-half the price that the obstetricians required.²¹ The doctors' drive to eliminate midwifery did not appear to lie purely in a belief that the practices of midwives were unsafe, that the midwives lacked knowledge, or that the health of mothers or infants were at risk, but in their desire to attain the social and financial standing enjoyed by the medical profession as a whole in the United States. Although the 20th century found obstetricians replacing midwives as the primary birth-attendant with increasing frequency, the maternal and infant mortality rates did not decrease in conjunction with these replacements. "In fact, the introduction of hospital-based and physician-attended births was associated with a dramatic increase in the rates of puerperal fever and maternal death."²²

Midwifery as a profession in the United States became organized in order to improve the quality of its care. Prior to 1955, the American College of

18. *Id.*

19. RICHARD W. WERTZ & DOROTHY C. WERTZ, LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA 46 (1979).

20. LITOFF, *supra* note 12, at 67 (quoting Joseph B. De Lee, *Progress Toward Ideal Obstetrics*, 6 TRANSACTIONS AM. ASS'N STUDY AND PREVENTION OF INFANT MORTALITY (1915)).

21. *Id.* at 73 (citing LOUIS S. REED, MIDWIVES, CHIROPODISTS, AND OPTOMETRISTS: THEIR PLACE IN MEDICAL CARE 17 (1932); Charles E. Ziegler, *The Elimination of the Midwife*, 3 TRANSACTIONS AM. ASS'N STUDY AND PREVENTION OF INFANT MORTALITY 222, 226 (1912)).

22. Hafner-Eaton & Pearce, *supra* note 2, at 815 (citing ANJA HIDDNGA, DUTCH OBSTETRIC SCIENCE: EMERGENCE, GROWTH, AND PRESENT SITUATION (1993)). See MARJORIE TEW, SAFER CHILD BIRTH? A CRITICAL HISTORY OF MATERNITY CARE ch. 7 (1990); Simone E. Buitendijk, *How Safe Are Dutch Home Births?*, in SUCCESSFUL HOME BIRTH AND MIDWIFERY: THE DUTCH MODEL 115, 120 (Eva Abraham-Van der Mark ed., 1993)).

Nurse-midwives and the American Association of Nurse-midwives had existed separately and for different purposes. When they merged, they became known jointly as the American College of Nurse-Midwives (ACNM) and prescribed educational standards for nurse-midwives and a nationwide accreditation program.²³ Although the midwives' profession was more organized by the 1950s, the popularity of physician-assisted birth was steadily rising. By this decade, "the infant and maternal mortality rate dropped, and the medical establishment was quick to take the credit. But it was more likely the establishment of prenatal care and blood banks, a generally improved diet, and discovery of antibiotics that led to a healthier childbearing population."²⁴ The medical profession continues to take credit today for improvements in the quality of childbearing, when in fact physician-attended hospital births have a significantly higher rate of infant and maternal mortality than do midwife-assisted births.²⁵ But again, history has shown that the interest of the obstetrician may not always reflect the pure interests of the mother or child, as the financial risk to the physician's career unfortunately becomes a motivating factor.

Organized obstetrics . . . has a clear financial interest in retaining pregnancy and childbirth within its exclusive domain. When the birth rate is high and the physician supply is low, . . . organized obstetrics behaves less territorially and is more likely to allow nonobstetrician physicians and nonphysicians a broader scope of practice. Similarly, if an abundance of low-income, unsponsored or geographically isolated patients exists, the profession will allow more legislative freedom to these practitioners to treat these "less desirable" patients. This may be particularly true if physicians perceive these patients as more difficult, time consuming, or more likely to file a liability suit. However, when there is an oversupply of physicians, or when well-insured patients are scarce, the profession is likely to tighten their reigns²⁶

23. Reilley, *supra* note 4, at 1121.

24. ALICE GILGOFF, HOME BIRTH 41 (1978).

25. Hafner-Eaton & Pearce, *supra* note 2, at 822-23.

26. *Id.* at 829.

An examination of U.S. midwifery history clarifies that it was not an advance in technology or increased concerns for infant and maternal safety, but rather the fear of a failing medical specialty which led to the lowly status of the midwife. Many doctors continue to espouse the virtues of hospital birth, claiming that the increased safety of physician-attended hospital births justifies the role of the midwife as merely a physician-assistant. The safety record of the independent midwife, however, demonstrates the irony of these statements.

III. THE RELATIVE SAFETY OF A MIDWIFE-ASSISTED BIRTH

The first rule of medicine--"*nir nocere*"--"injure nothing." The primary objective of the physician is to find the least invasive, most prudent avenue to maintaining health. He examines an individual for signs of infirmity and, at the very least, does nothing to cause any further damage. The attitude that childbirth is inherently dangerous, instead of innately normal, has led obstetricians to injure countless mothers and babies in unnecessary and misguided haste to protect them. In numerous multinational studies, home births and hospital births attended by midwives have been found to be dramatically safer, with infant mortality rates less than half the rates of physician-assisted hospital births.²⁷ In a well-known 1986 study, the perinatal mortality rate was "higher for doctors in hospitals (18.9 in 1,000), than for doctors at home (4.5 in 1,000), than for midwives in hospitals (2.1 in 1,000), than for midwives at home (1 in 1,000)."²⁸ Hospitals are in fact a more dangerous environment as an infant runs a much higher risk of picking up various diseases in a germ-filled institution than it does in its own home. The invasive technologies employed by obstetricians in a hospital setting result in statistics which show

babies born in the hospital are six times more likely to suffer distress during labor and delivery, eight times more likely to get caught in the birth canal, four times more likely to need resuscitation, four times more likely to become infected, and

27. SHEILA KITZINGER, *WOMEN AS MOTHERS: HOW THEY SEE THEMSELVES IN DIFFERENT CULTURES* 42-43 (1978).

28. Hafner-Eaton & Pearce, *supra* note 2, at 823.

thirty times more likely to become permanently injured.
Their mothers are three times more likely to hemorrhage.²⁹

It is important to note, however, that when a woman chooses a midwife as her birth attendant, she is not immediately accepted as a client. Midwives examine each pregnant woman and “screen” her for high-risk factors which would make her delivery potentially dangerous or complicated, such as high blood pressure, diabetes, or heart problems. These women are then referred to obstetricians for further care and assistance in delivery. Midwives are not medical experts and do not attempt to assert their domain over women to whom midwife’s techniques would be useless. The screening process is not a fixed checklist of physical considerations; rather it is based on the mother as a whole person, including her mind, body, philosophy, emotions, and surroundings. This screening procedure has yielded a substantially higher rate of accuracy in predicting high-risk mothers than has the strict application of medical criteria.³⁰ While the woman is actually experiencing the initial stages of labor, the midwife is in attendance evaluating “the woman’s physical condition, uterine contractions, cervical dilations and fetal heart. By monitoring all indicators . . . the [midwife] can determine that the labor is normal” and that it is therefore safe for her to continue in assisting the birth.³¹ When data are compared, studies show that planned home births where the screening procedures are employed result in lower rates of intervention, complications, morbidity, and mortality than hospital or unplanned births. In a retrospective study of 1,707 births, including births which took place at The Farm Maternity Center in Tennessee (a well-known midwife birthing center), A. Mark Durand, M.D., M.P.H., found that the hospital birth group had more than a ten-fold increase in c-section deliveries (16.46 percent for the hospital birth group versus 1.46 percent for the midwife-assisted center births), and the difference in amount and intensity of delivery intervention was still greater (26.60 percent versus 2.11 percent).³² The comfort, familiarity, and trust which accompany midwife-assisted births are often recognized as factors which contribute to the high level of success in healthy, normal births.

29. ROBERT MENDELSON, M.D., *CONFESSIONS OF A MEDICAL HERETIC* 152-53 (1979).

30. *Id.* at 916-17.

31. Barbara A. McCormick, *Childbearing and Nurse-Midwives: A Woman’s Right to Choose*, 58 N.Y.U. L. REV. 661, 667 (1983).

32. A. Mark Durand, M.D., M.P.H., *The Safety of Home Birth: The Farm Study*, AM. J. PUB. HEALTH, Mar. 1992, at 451-52.

Midwives who have been practicing in the home have reported that the "incidence of postpartum depression is virtually non-existent in home birth mothers,"³³ a common occurrence among the hospital-birth population.

The disparity in rates of intrusive procedures performed on those mothers selected as appropriate for midwife-assistance, and those mothers who employ physicians, is due to the difference in philosophy between these two birth attendants. Doctors are experts in detecting problems and complications, whereas a midwife is trained to assist in a birth as the natural, normal experience it is. A midwife does not "deliver" a child, as many obstetricians are so fond of claiming, but rather she aids the *mother* in this endeavor. In contrast to the intrusiveness of hospital births, a midwife minimizes interference and enables the woman to make childbirth decisions, thereby encouraging her to control her body. Many of the so-called complications which doctors insist require their expertise are, in fact, caused by the physicians themselves in their handling of the delivery. For example, the use of the lithotomy position for a birthing mother (lying horizontally on the back with legs in the air) is the least effective and most dangerous position.³⁴ It is however, employed for the convenience of doctors who may then sit comfortably positioned in view of the mother's genital area. The lithotomy position can cause labor to slow due to lack of gravity, compress the vena cava (which often leads to fetal distress), and increase pain which will often persuade the mother to take pain medication or further drugs to hasten the labor.³⁵ If the position is used during the bearing-down stage, it may necessitate the use of forceps and/or episiotomy³⁶ ("surgical slicing of the [vagina] to widen the opening"³⁷). Dr. Robert Caldeyro-Barcia studied the behavior of 145 women in the late 1970s to determine what position the mothers would choose if they were not restricted. The study showed that 95 percent of the women chose to be vertical during their labors.³⁸ The vertical position is not only more comfortable for laboring women, but it also results in shorter labors as well as the almost complete disappearance of fetal distress due to cord compression.³⁹

33. Charles Wolfson, *Midwives and Home Birth: Social, Medical, and Legal Perspectives*, 37 HASTINGS L.J. 909, 915 (1986).

34. Hafner-Eaton & Pearce, *supra* note 2, at 817.

35. *Id.* at 817-18.

36. See Michel Odent, *THE NATURE OF BIRTH AND BREASTFEEDING* 39 (1992).

37. MENDELSON, *supra* note 29, at 96.

38. NANCY W. COHEN & LOIS J. ESTNER, *SILENT KNIFE* 158 (1983).

39. *Id.* at 159.

Episiotomies, another favored technique of obstetricians, are performed as "standard procedure" in many hospitals. Obstetricians often believe that an episiotomy will prevent the mother from having other more painful tearing which can be ragged and difficult to repair. Dr. Lewis Mehl found that in a group of doctor and midwife assisted home births, only five percent of the midwife-attended mothers who delivered without an episiotomy suffered lacerations, while forty percent of the doctor-attended mothers did. "The chief difference in care was that the midwives practiced massage of the birth area as the head emerged, a procedure the doctor had never learned."⁴⁰ The operation is not only unnecessary, but it can lead to increased incidence of infection. It is responsible for almost twenty percent of maternal deaths.⁴¹ In Scandinavian countries, where all of the world's lowest infant and maternal mortality rates are enjoyed, episiotomy is performed on less than six percent of new mothers, while in the United States and Canada, the operation is performed on close to ninety percent of new mothers.⁴²

Two U.S. studies performed in the 1980s showed that between thirty-three and seventy-five percent of the c-sections performed in U.S. hospitals were unnecessary.⁴³ The rate of cesarean section (c-section) in the United States is the highest rate in the world at close to twenty-five percent of all births. The rate has steadily increased from 5.5 percent in 1970 to its current level where one in four babies are delivered by c-section.⁴⁴ It is a striking comparison that the rate of c-sections in one twelve-year study showed that less than two percent of women who delivered with the assistance of a midwife (generally in urban hospitals) required a c-section.⁴⁵ A comparison against the ethnically diverse Netherlands is perhaps more informative, as its infant mortality rate is 60 percent of the United States'; however, less than eight percent of its births result in c-section.⁴⁶ The rate of unnecessary c-section is shocking not only because of the intrusiveness of such a procedure, but because it goes directly

40. GILGOFF, *supra* note 24, at 70.

41. ROBERT S. MENDELSON, M.D., *MAL(E) PRACTICE: HOW DOCTORS MANIPULATE WOMEN* 179 (1981).

42. *Id.* at 178; Litoff, *supra* note 12, at 192.

43. THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *THE NEW OUR BODIES, OURSELVES* 384-85 (1984) [hereinafter *NEW OUR BODIES, OURSELVES*].

44. Hillary E. Berkman, Note, *A Discussion of Medical Malpractice and Cesarean Section--Student Symposium on Women and the Law*, 70 OR. L. REV. 629, 629 (1991).

45. Amy Cunningham, *The Rebirth of Midwifery*, PARENTING, Apr. 1995, at 100.

46. American College of Obstetrics and Gynecologists, *Are Primary Cesarean Section Rates Too High?*, OB/GYN NEWS, 1981, at 3.

against the primary objective of the physician to "injure nothing." The risk of maternal death is four to five times greater with a c-section than with a normal vaginal delivery and the risk of general harm (infection, loss of blood, anesthesia complications, and mortality) is about ten times as great.⁴⁷ Although such an offensive rate of c-sections persists, there does not appear to have ever been a winning malpractice case in either the United States or Canada in which a woman has prevailed on the grounds that a doctor performed a c-section unnecessarily. Perhaps the common sentiment is that as long as the mother and child recover well from the procedure, the fact that the operation was unnecessary becomes immaterial and should not be viewed as crossing the line of injury. One state court has gone so far as to hold that a c-section does not constitute a "physical injury" because it is a "surgical procedure which is an accepted method of delivery."⁴⁸

However, as Dr. Gerald Stober points out, "the most common cause of cesareans today is not fetal distress or maternal distress but obstetrician distress."⁴⁹ The current trend toward a more litigious society has physicians practicing "defensive medicine,"—the performance of otherwise unnecessary tests and procedures to ensure prudent medical decisionmaking and results.⁵⁰ The most common reasons listed by physicians for performing c-sections at such an alarming rate include the following: possible malpractice liability, a standard policy of repeating c-sections (although such a trend is no longer recommended by the American College of Obstetrics and Gynecology), general obstetric training, an assumption that c-sections result in healthier babies, financial interests, obstetrical technology (such as fetal monitoring), birth weight, and serious medical condition.⁵¹ However, the belief that c-sections result in healthier babies is not dependable because although the United States has the highest rate of c-sections in the world, twenty other countries have lower infant mortality rates.⁵² A baby born in many areas of Canada, a country which has an even more limited recognition of midwives than the United States, would have a better chance of survival if it were born in Singapore or Costa Rica; yet the high rate of c-section in the United States

47. Berkman, *supra* note 44, at 635.

48. *Seusa v. Mastor*, 525 N.Y.S.2d 101 (1988).

49. NEW OUR BODIES, OURSELVES, *supra* note 43, at 385.

50. Vicki Elson, *A Landmark Verdict on an Unnecessary Cesarean that Caused Serious Complications*, JAMA, Mar. 22, 1994, available in LEXIS, News Library, Mags File.

51. Berkman, *supra* note 44, at 630-31.

52. *Id.* at 633.

and Canada appears to be justified by a belief that the procedure will improve such statistics. Marsden Wagner of the WHO states the following in a letter to the Washington Post:

Experimental trials comparing the safety of midwives and doctors at birth, published in American and international journals, all show the same result: there is far less intervention during birth such as unnecessary forceps and unnecessary cesarean section (both have real risks for the woman and baby) if a midwife is the chief birth attendant and yet the outcome for both mother and baby is just as good with the midwife. Further proof of the safety of midwives is that, while doctors attend over 80% of U.S. births and midwives attend over 80% of births in the Scandinavian countries (and there is never a doctor in the room at any time during the entire birth), the [United States] loses many more babies around the time of birth than the Scandinavian countries. It would be humorous if it wasn't pathetic to hear U.S. obstetricians try to explain away these facts using myths such as homogeneous populations and bigger pelvises in these countries.⁵³

The factors which result in the decision to perform a c-section may be justifiably medical in nature, but often the medical procedures themselves are what result in the decision. Often a physician's hectic calendar will result in either induced labor or a drug-enhanced, hurried labor. These "scheduling" difficulties along with "customary" procedures, such as use of an I.V., which can dilute hormones, and use of fetal monitoring, both of which can limit movement, can result in a less-than-ideal progression in labor. Often the restricted movement of the mother will cause her labor to fall below normal and the doctor may break the amniotic sac to "speed things up." The sac is protection for the fetus, the loss of which often causes fetal distress and consequently, cesarean section.⁵⁴

53. Marsden Wagner, *Letter to the Editor of the Washington Post* (visited April 23, 1997) <<http://frognet.net/~midwife/wagner.html>> (letter of June 8, 1996, responding to two articles regarding a midwife charged in a newborn infant's death).

54. Anne Pico, *A Sensible Look at Home Birth*, COUNTRY & SMALL STOCK J., May 1994, at 56.

Although doctors often argue against home birth on the ground that the fetus is incapable of giving its consent, neither is the fetus capable of consenting to conventional obstetric procedures [such as forceps, fetal monitoring, c-section or drugs]. The same doctors who argue that all "non medical" desires of the mother should be subordinated to the baby's safe birth, also argue that she has a right to pain relief, thus placing her physical comfort ahead of possibly deleterious health effects for the child.⁵⁵

IV. LAWS GOVERNING THE STATUS OF MIDWIVES WORLDWIDE

The countries which recognize midwifery regulate the profession in very distinct ways, enacting a wide spectrum of differing laws. Sweden and the Netherlands have the world's best example of effective midwifery-assisted childbirth policies. The United Kingdom has also dealt successfully with the demand for, and the practicality of, the midwife as a birth-attendant. On the contrary, the United States and Canada are examples of countries which fail to recognize the importance, both in infant and maternal mortality rates and cost, of sanctioning the midwife profession's legal autonomy. The United States and the United Kingdom will serve as the major comparison between an unnecessarily restrictive and inhibiting structure of laws and a more healthy and cost effective model.

CNMs in the United States are managed and coordinated by their national organization, the American College of Nurse-Midwives, and were originally certified by that group. However, in 1993 the government assumed control under the ACNM Certification Council. In the United States, CNMs are expressly permitted to work in all fifty states,⁵⁶ however their practice is restricted to the hospital setting for the majority of their work. In most states they are also required to have physician back-up for any deliveries they attend,⁵⁷ which in effect requires physician approval of all midwife practices. CNMs are, in essence, bound to the hospital setting. In order to secure the physician-backup which is legally required, CNMs must work in the environment where such physicians will be. Furthermore, to maintain hospital

55. Wolfson, *supra* note 33, at 920.

56. Reilley, *supra* note 4, at 1125.

57. Hafner-Eaton & Pearce, *supra* note 2, at 820.

privileges, the CNMs must follow hospital policies, which in the majority of major urban hospitals, means no assistance at homebirths. CNMs are unavoidably relegated to the decisions laid out by the policies of the hospital and the obstetrician, whose interventionist philosophy is in direct conflict with midwifery training and expertise. Fear of malpractice suits also leads the authorizing obstetrician to practice "defensive medicine," often including procedures such as episiotomies and c-sections. Obstetricians may, for the most part, be content to allow CNMs to practice unaided; however, the reality of malpractice weighs heavily on the authorization decisions that are required from the physician, the individual ultimately at financial risk for any complications.

Lay-midwives in the United States, on the other hand, are a fragmented group because they have no national structure. The states acknowledge differing aspects of the lay-midwifery profession, recognizing a wide variety of allowable practices. Three basic state schemes are presently employed: (1) statutory recognition of both nurse- and lay-midwifery, but the denial of legally necessary licenses to lay-midwives; (2) authorization of the practice of nurse-midwifery, but no recognition or regulation of lay-midwifery; or (3) statutory recognition of both lay-midwifery and nurse-midwifery but differing standards and restrictions placed on each.⁵⁸ Despite the existence of laws in many states which purport to recognize midwifery, lay-midwives face obstacles laid out by the very legislatures that claim to acknowledge them. These state legislatures often refuse to issue licenses to lay-midwives or delegate the responsibility of licensing to administrative regulatory boards which institute requirements unrealistically difficult for a lay-midwife to satisfy, thereby ultimately undermining the purpose of their own state statutes.⁵⁹

Many states' laws forbid the "unlicensed practice of medicine," yet these laws do not define midwifery as the practice of medicine. This charge, however ambiguous, is a recurrent theme in the prosecution of midwives.⁶⁰ "The way the law is being applied would imply that anyone assisting a woman in birth, including her husband or a taxicab driver, is criminally liable—is in fact practicing without a license. One effect of this law would be that only a

58. Reilley, *supra* note 4, at 1127-31.

59. *Id.* at 1130.

60. *Id.* at 1133.

completely unattended home birth is a legal one."⁶¹ Some of the states claim that prosecution based on licensing laws is necessary to protect the public's health and welfare. However, as midwife and homebirth advocates have pointed out,

if the state were concerned with protection rather than preserving a certain status quo, why [do they] resort to costly administrative and legal harassment, when there are more productive options? If [the state were] truly concerned about those mothers and infants, it would make sure midwives were supported in doing their job properly.⁶²

In some states, assisting a woman in delivering a baby without a license is a class D *felony* punishable by 3-10 years in *prison* and a hefty fine.⁶³

The major difficulty facing midwives in the United States is the influence which the medical profession has over the health-policy decisions of state legislatures. When issues of infant and maternal health in childbirth are presented to legislative committees, those committees are inclined to rely on the opinions of the very profession most adamantly opposed to the independent legal status of midwives. Often what legislatures do not recognize is that they are placing their confidence in the beliefs of a profession which has its financial well-being at stake. As far back as 1907, midwives were struggling to be independent of the medical stronghold. In a case decided by the Supreme Judicial Court of Massachusetts, *Commonwealth v. Porn*, the court stated that "childbirth is not a disease, but a normal function of women"⁶⁴ The Court went on to say, "we are far from saying that it would not be within the power of the Legislature to separate by a line of statutory demarcation the work of the midwife from that of the practitioner in medicine."⁶⁵ As much as the court conceded to the importance of midwifery in the area of childbirth, it set a precedent of judicial concession to medical standards.⁶⁶

61. Anneke Campbell, *Midwife on Trial*, E.W.J., Mar. 1990, at 115.

62. *Id.*

63. Steve Hinnefeld, *State Task Force Seeking to Legalize Midwifery*, HERALD TIMES (Bloomington), Jan. 23, 1995, at A1.

64. 82 N.E. 31, 31 (Mass. 1907).

65. *Id.* at 32.

66. Hafner-Eaton & Pearce, *supra* note 2, at 823.

Legal code, in turn, seems to reflect the prevailing values of a profession allowed by our society to formulate and influence social norms. Often social norms are not based on epidemiological data that show long-term health trends or outcomes on large populations; rather they are shifted, manipulated, or maintained by key power-holding groups who may have vested interests.⁶⁷

Canadian law is similarly influenced and remains largely hostile to the idea of midwife autonomy. Until recently, no province in Canada afforded legal status for either nurse- or lay-midwives. In early 1995, the British Columbia government passed a bill which granted legal autonomy to midwives and established a college and standards of practice.⁶⁸ This action may be the beginning of a trend toward increasing birth options for Canadian women. At present, however, Canada remains one of eight nations in the WHO's 210 nation membership that does not recognize midwifery. "Canada is not frequently associated internationally with Panama, El Salvador, Venezuela, Columbia, Honduras, the Dominican Republic and Burundi."⁶⁹

The most startling aspect of the status of midwives in Canada lies in the continuing struggle for midwife recognition despite the establishment of a socialized, comprehensive, health-care system.⁷⁰ Notwithstanding the development of a universal-health care system, Canada has followed the same path as the United States to midwife subordination. In both the United States and Canada, nurses and physicians had professional interests in retaining their control over childbirth. In Canada, however, the nursing profession itself can be faulted for blocking midwives from the practice of birth-attendance. Obstetrical nurses often positioned themselves as substitutes for midwives and were better received by physicians because they willingly accepted the "less than prestigious position of 'doctor's handmaiden' . . . [who was] expected to show 'wifely obedience to the doctor.'"⁷¹ The midwives who continued to

67. *Id.* at 831.

68. Shari Graydon, *Midwifery Promises Women More Birthing Options*, VANCOUVER SUN, June 3, 1995, at A21.

69. Lee Ann Schienbein, *Midwifery: A Woman's Labour, A Woman's Choice*, 58 SASK. L. REV. 173, 184 (1994) (citing J. Mason, *Midwifery in Canada*, in *THE MIDWIFE CHALLENGE* 98 (1988)).

70. BENOTT, *supra* note 7, at 41.

71. *Id.* at 44 (citing S. Buckley, *Ladies or Midwives: Efforts to Reduce Infant and Maternal Mortality*, in *A NOT UNREASONABLE CLAIM* (L. Keadley ed., 1979)).

practice independently were eventually overshadowed by physicians and their nurse-subordinates, who were viewed as inferior despite their nurses' training.

In the United Kingdom, both nurse-midwives and lay-midwives have practiced independently since the 1902 Midwives Act. The most recent legislation affecting the status of midwives has been the Nurses, Midwives and Health Visitors Act of 1979.⁷² The purpose of that Act was to replace the separate bodies regulating education, training, and certification of those professions, with a central U.K. Council. Separate national boards controlled by each country in the United Kingdom supplement the Council.⁷³ The majority of each board is directly elected by the profession it regulates. The Council's purpose is to establish and improve the standards of training and discipline within the professions by implementing rules which give effect to the Act.⁷⁴ The Council makes rules which (1) determine the circumstances in which a midwife may be suspended from practice, (2) require a midwife to give notice of her intention to practice to local supervising authorities, and (3) require registered midwives to attend continuing education courses.⁷⁵

In 1973, the United Kingdom joined the European Economic Community (EEC) and became subject to its directives.⁷⁶ In 1980, the EEC passed the European Economic Community Midwives Directive⁷⁷ which forced the United Kingdom to alter its midwife education program in response to the European Economic Standards. Before this directive was passed, the United Kingdom's procedure was very similar to that of the United States. Midwives were required to attain a nursing degree and then continue with further midwifery training. The 1980 directive allowed for a three year *direct entry* program which required no prior training, aside from a general education. However, if a certified nurse chose to obtain further midwifery training, the directive also allowed a year and a half certification program for those individuals.⁷⁸ Under the United Kingdom's system, a lay-midwife may attain certification through a recognized training program without a nursing degree

72. Nurses, Midwives and Health Visitors Act, 1979, ch. 36 (Eng.).

73. John Finch, Annotation, *Nurses, Midwives and Health Visitors Act, 1979*, CURRENT LAW STATUTES ANNOTATED (Sweet & Maxwell 1979).

74. 30 HALSBURY'S LAWS OF ENGLAND, para. 401 (the Right Honourable Lord Hailsham of St. Marylebone, Lord High Chancellor of Great Britain ed., 1992).

75. *Id.* at para. 409 (the rules as to midwifery practice are Nurses, Midwives and Health Visitors Rules 1988 pt. V (rules 27-44) (substituted by rules approved by SI 1986/786)).

76. Treaty of Accession I, 1972, arts. 1, 2, 1972 O.J. SPEC. ED. (L73).

77. EC Council Directive 80/155, art. 4, 1980 O.J. (L33).

78. *Id.* at art. 1(2), (3).

and at no charge to her whatsoever. The Royal College of Midwives was relieved when the United Kingdom became subject to the EEC requirement for a three-year education program because this program removes midwifery from the general field of nursing. Through this program, the midwife learns about the process of healthy pregnancy and birth and the philosophy of nonintervention before the midwife encounters medical and nursing illness concepts.

The interests of midwives are well protected under the United Kingdom's regulatory scheme because midwives have direct input into the decisions which govern them. The U.K. Central Council has a standing midwifery committee which consists of at least four practicing midwives, as well as two registered medical practitioners.⁷⁹ The Council must consult the committee on all matters which concern, or are relevant to the practice of midwifery, including education, training, certification, and disciplinary action for malpractice or misconduct.⁸⁰ The Act provides that midwives will be generally supervised by the National Health Services authorities.⁸¹ Such authorities' duties include both the examination of *prima facie* cases of misconduct as well as the power to suspend midwives from practice. However, both of these supervisory powers are exercised in accordance with the Council's rules; and all such rules are made by the Council only after consultation with the midwifery committee.⁸² The committee is also responsible for determining the qualifications necessary to become a local supervisory authority. Essentially, through the midwifery committee's implicit rulemaking power, the profession has the ability to set its own standards and police its own members.

Once a midwife has been certified as knowledgeable and trained to practice, she must be registered as an active, professional midwife. In the United States this registration is done at the state level through licensing. In the United Kingdom, the U.K. Central Council has been responsible for registration since the 1979 Nurse, Midwives and Health Visitors Act. The governing of standards, certification, and regulation by a central unit eliminates the need for licensing by separate provinces or countries. Midwives

79. Nurses, Midwives and Health Visitors Act, *supra* note 72, at § 7; Nurses, Midwives and Health Visitors Order (Midwifery Committee of Central Council) 1982, SI 1982/1567, art. 2(1).

80. 30 HALSBURY'S LAWS OF ENGLAND, *supra* note 74, at para. 469.

81. Nurses, Midwives and Health Visitors Act, *supra* note 72, §§ 16.1, 16.2. See Nurses, Midwives and Health Visitors Rules, *supra* note 75.

82. See ENCYCLOPEDIA OF HEALTH SERVICES AND MEDICAL LAW 2-472, 2-481 (Sweet & Maxwell 1991).

only need register once for the entire United Kingdom, with notification passed along to a local district supervisor of a midwife's intention to practice there. Once registered, the midwife is free to either establish an independent practice or to seek employment with a group of midwives or physicians. Midwives have been able to practice independently since the 1902 Midwives Act and they have been authorized to use anesthetic gases or injections, even in homebirth environments, since 1936.⁸³ In contrast to the subordinate, secondary status of their U.S. and Canadian contemporaries, they do not need the authorization, signature, or collaborative examination of a physician in order to attend at a birth.

Sweden's maternity-care arrangement is perhaps the ideal for the practice of midwifery in the world. The occupational autonomy of midwives has increased, rather than decreased with the modernization of health care and the development of a welfare State.⁸⁴ The modern system contains three basic components: (1) comprehensive health care for all birthing mothers and babies free of charge, (2) a three-level hospital scheme based on a midwifery model of care, and (3) a national birth register.⁸⁵ Swedish maternity care is decentralized in a manner which avoids the placement of birthing mothers in large hospitals. Instead, care is given in local "mothercare centres" which are often close to home and focused solely on the natural process of childbirth. These centers are categorized as "Type-I Clinics" and they handle all normal, low-risk deliveries within their area. Any special cases are referred to a practitioner working in a "Type-II Clinic"; and only if a serious medical risk is discerned, is the client transferred to a "Type-III Clinic."⁸⁶ This process of screening "separates normal from potentially complicated pregnancies and assigns each to their appropriate environment."⁸⁷ Midwives are viewed as trained professionals who are experts in their field. With the lowest infant

83. Nurse, Midwife and Health Visitors Rule 41 lists three limitations on a midwives' authority to administer medicine and other forms of pain relief: (1) a midwife may not administer medicine, including analgesics, unless she has been instructed in her training in its use and is familiar with the dosage and methods of administration or application, (2) a midwife may only administer a medicine or analgesic through an apparatus approved by the Council, and on recommendation of the Board, as suitable for use by a midwife; the apparatus must have been properly maintained, and (3) a midwife may not use any apparatus or pain relief that is not approved by the Council unless instructed to do so by a medical practitioner. *Supra* note 75.

84. BENOIT, *supra* note 7, at 25.

85. *Id.* at 26.

86. *Id.* at 27.

87. *Id.* (quoting BRIGETTE JORDAN, BIRTH IN FOUR CULTURES: A CROSS-CULTURAL INVESTIGATION OF CHILDBIRTH IN YUCATAN, HOLLAND, SWEDEN AND THE UNITED STATES (1988)).

mortality rate in the world, not only are midwives respected for their knowledge of childbirth, but for their ability to maintain integrity and a sense of well-being in their clients.

The Netherlands accords a similar legal status to the profession of midwifery with two fundamental differences. First, the national insurance system does not cover normal maternity care. Midwifery expenses, as well as any hospital delivery expenses except those involving serious medical complications, are based instead on a fee-for-service model. Second, the recognized workplace of the midwife is the home, as opposed to hospitals or birthing centers recognized in most other countries.⁸⁸ Neither the homebirth model, nor the fee-for-service system of reimbursement, has compromised maternal or infant safety or the quality of care. The Netherlands annually ranks among the top three to four countries in the world with the lowest infant mortality rates. Once again the logic supporting Canadian and U.S. resistance to homebirth as a viable option for birthing mothers weakens in light of these statistics.

V. THE EFFECT OF MALPRACTICE LIABILITY ON THE RECOGNITION OF MIDWIVES

The ability of midwives to practice independently in the United Kingdom but not in the United States is furthered by a fundamental difference in malpractice management. Malpractice is a major concern for professionals in the United States. Physicians practicing “defensive medicine” can decrease their patients’ overall care and well-being, while simultaneously increasing the demand for midwives’ special attention and care. Many midwives however, are not able to practice, either independently or with a physician, because of the prohibitive cost of malpractice insurance.

In the United Kingdom, malpractice is a comparably serious matter; however, management of such issues is handled more uniformly and ultimately, perhaps, more effectively. Malpractice and misconduct by medical and midwife professionals are, by United Kingdom standards, best dealt with by a committee of the professional’s peers. The Central Council’s professional committees have the responsibility of hearing and deciding disciplinary and misconduct concerns. Until 1950, the strength of the belief that these matters are most effectively handled by a group of similarly-trained individuals was

88. *Id.* at 28-29.

so firm that the British courts had absolutely no jurisdiction to hear appeals from the committees' rulings. Although this authority was eventually granted, courts are still generally unwilling to interfere with decisions made by the profession's committees.⁸⁹ One of the strongest illustrations of judicial reluctance to overturn the rulings of the professional committees is found in *McCoan v G.M.C.*. In this 1964 British case, although the Court was unable to find any public damage and further pointed out that the complaint in question had been made on grounds that were extraneous to the charge and therefore the charge should have been dropped, it still held that the supervision of medical professionals had always been best left to the committee and upheld their decision. "[T]hey know and appreciate better than anyone else the standards which responsible medical opinion demands of its own profession."⁹⁰ A later case, *Libman v G.M.C.*, held similarly that "an appellate court can reverse . . . [only] . . . where it would appear that the committee has misread the evidence to such an extent that they were not entitled to make a finding in the state of the evidence presented to them."⁹¹ Although both of these cases refer to physicians, the same reluctance has been evident in midwifery cases brought on appeal. As early as 1907 in *Re Feldmann*, the Court stated that an appeal is only "with reference to the decision of the board upon the materials properly before them."⁹²

The disparity in legal philosophy between the United States and United Kingdom, with reference to malpractice issues, is perhaps best understood as a difference in philosophies of liability. In the United States a professional is held to a model of reasonable care consistent with a "standard minimum of special knowledge and ability."⁹³ This rule is explained to a jury of laymen who are then entrusted with the responsibility of defining that standard of special ability. These jury members must ultimately decide whether the professional at issue has met this arbitrary rule. A jury will most likely consist of people who have no experience with or knowledge of the standards of the medical profession. Juries must depend therefore, solely on what can be presented within the confines of a trial. The attorneys have limited

89. See *ENCYCLOPEDIA OF HEALTH SERVICES AND MEDICAL LAW*, *supra* note 82, at 1-19.

90. *McCoan v. Gen. Med. Council*, 3 All E.R. 143, 147 (P.C. 1964).

91. *Libman v. Gen. Med. Council*, 1972 App. Cas. 217, 221 (P.C. 1971) (appeal taken from Disciplinary Committee of Gen. Med. Council).

92. *Re Feldmann*, 97 L.T.R. 548, 551 (K.B. 1907).

93. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 32, at 185 (5th ed. 1984).

opportunity to explain the complex mental process a professional goes through to arrive at his decision to take a certain course of action. This concept of liability is based on the sympathies of an uninformed group of laymen who are judging a professional's conduct based on what they feel would have been the best treatment for the individual plaintiff. Understanding what standard is "good medical practice," which is to say, what is customary and usual in the profession,"⁹⁴ is more difficult still because in the United States, that standard is not *necessarily* based on the prevailing opinion of the profession, but rather,

where there are different schools of medical thought, and alternative methods of acceptable treatment . . . , the doctor [or midwife] is entitled to be judged according to the tenets of the school the doctor [or midwife] professes to follow A "school" must be . . . the line of thought of a respectable minority of the profession.⁹⁵

The United Kingdom however, uses the idea of "situation liability," which explains the link between ordinary malpractice and public health concerns.⁹⁶ Often, even a foreseeable risk can be justified in reference to some other value of the act to public health issues generally.⁹⁷ The professional's conduct is not judged against what that professional professes to be his "school of thought," nor against what a panel of laymen decide would have been the ideal treatment for that individual, but rather against the background of the environment in which the conduct was made.

[T]he standards of the profession at the date of the untoward incident are applied They do not merely weigh heavily; they determine the issue. Nor does it matter that a separate school within the profession considered a practice as carrying an unnecessary risk of injury; what does matter is that the

94. *Id.* at 189.

95. *Id.* at 187. The addition of "midwife" to the quote is necessary to examine the United States law as a parallel to the United Kingdom law where midwives are recognized professionals who are held up to a standard of malpractice in a similar way as physicians. See *Joy v. Chau*, 377 N.E.2d 670 (1978).

96. See *ENCYCLOPEDIA OF HEALTH SERVICES AND MEDICAL LAW*, *supra* note 82, at 1-41.

97. *Id.* at 1-42.

practice was acceptable, at that time, to a substantial body of opinion within the calling as a whole.⁹⁸

This standard of "situation liability" enables a midwife or other medical professional to practice without fear. She knows that if her conduct is questioned, it will be presented to a committee of her peers, who will examine the medical situation in which the decision was made and not look predominantly at the sympathies involved in the individual case. A midwife, as an independent practitioner, is personally liable for any wrongful acts committed by her; a physician is not responsible for her conduct unless that doctor is her employer.⁹⁹

Countries with universal health care systems lessen the incentive for malpractice suits because, in addition to a more reliable standard of professional responsibility, the professional herself does not risk her financial security to the degree she would in a country without such a system. In the United Kingdom, every child is guaranteed the provision of comprehensive health care during his life by the National Health Service. Little motivation exists for parents of an injured child to fabricate or embellish the misconduct of a birth-attendant. Charges of malpractice are a disciplinary matter, not an issue of financial recovery for parties who choose to bring them. Both United Kingdom physicians and midwives hold salaried positions paid by the National Health Service, which reduces the monetary potential for any liability judgment against them and consequently reduces their attractiveness as targets for malpractice claims.

In the United States, as an example of a country that does not provide universal health care coverage, the incentive to bring malpractice actions against physicians or midwives is greatly increased. When a child is injured, parents have the responsibility of providing health care possibly for the child's entire life. Insurance covers only a limited amount of the lifetime commitment to a disabled child, and the alternatives for such parents are few. A malpractice action often gives these parents the one opportunity to recover the

98. *Id.* at 1-41 (citing *Roe v. Minister of Health*, 1954 Q.B. 66 (Eng. C.A.); *Maynard v. West Midlands RHA*, 1 All E.R. 635, 635 (H.L. 1985); *Bolam v. Friern Hosp. Mgmt. Comm.*, 1 W.L.R. 582, 582 (Q.B. 1957); *Slater v. Baker*, 95 Eng. Rep. 860, 862 (K.B. 1767)).

99. Nurses, Midwives and Health Visitors Act, *supra* note 72, at para 405. In *Walker v. S.W. Surrey Dist. Health Auth.*, a midwife was found liable for injecting petnidino to the side of plaintiff's right thigh contrary to good practice. *Walker v. S.W. Surrey Dist. Health Auth.* (17 June 1982, unreported).

costs which will burden them, regardless of whether a real basis exists for asserting fault or negligence on the part of the birth assistant.

It is interesting to note however, that although the high cost of insuring against such malpractice actions keeps many midwives from practicing in the United States, of those practicing in 1985, only six percent had ever been named in a malpractice suit, while sixty percent of obstetricians had been sued.¹⁰⁰ The poor status of midwives as an object of malpractice judgments due to their comparatively low incomes may account for this striking statistical discrepancy; however, one of the most elemental explanations lies in the type of relationship which develops between a midwife and her client. This bond is generally very strong as the mother and midwife work closely throughout the pregnancy to achieve a healthy birth. This relationship is often absent in the doctor-patient arena where the physician is not seen as a birth companion, one who encourages the woman to control her own health choices, but rather as a distant medical technician who appears magically a few moments before the mother is about to deliver. The breakdown which commonly occurs in this relationship has been used to explain the much higher rate of obstetrical malpractice claims.¹⁰¹ This sort of breakdown is not an issue in most midwife-client relationships because the women have come to trust one another and understand the advantages and limitations of a midwife-assisted birth.

VI. THE COST-EFFECTIVENESS OF MIDWIFE-ASSISTED BIRTHS

The United Kingdom's National Health Service allows midwives and other health professionals a measure of independence and security not often duplicated in other countries. The National Health Service's single payor capitation system with hospital ownership, State control of pricing, and State employment of health care workers, is perhaps the most efficient method of providing universal care to date.¹⁰² Canada's health care service, although

100. Gail A. Robinson, *Midwifery and Malpractice Insurance: A Profession Fights for Survival*, 134 U. PA. L. REV. 1001, 1015 (1986) (citing *Midwives Face Threat of High Insurance Cost*, N.Y. TIMES, Sept. 29, 1985, at A56. "Despite these statistics, insurers justify the increased rates by reference to the increase in the number of malpractice suits and high jury awards. They also question the concept of a low-risk birth. One insurer asked, 'How do you know it's a low-risk birth until it's over?'" *Id.* at 1015 n.75 (quoting Philip Bies, President, Medical Malpractice Insurance Association)).

101. *Id.*

102. See generally J. ROGERS HOLLINGSWORTH ET AL., *STATE INTERVENTION IN MEDICAL CARE: CONSEQUENCES FOR BRITAIN, FRANCE, SWEDEN, AND THE UNITED STATES 1890-1970* (1990) (surveying the United Kingdom's National Health Service).

organized in a similar fashion to the United Kingdom's system, lacks the same commitment to quality of care and the guarantee of control and choice in personal health decisions. Because there is little or no cost to the birthing mother for health care in Canada, she hardly has an incentive to question the amount and necessity of diagnostic testing, standard procedures, and fees which are imposed.

Health care is increasingly considered to be a consumer product, and as such, warrants attention to factors such as cost and quality. This attitude prevails in Canada as well as the United States. Although health care cost is no longer a factor with which individual Canadians need be concerned, the quality of care is of vital importance.¹⁰³

The United States is in a state of health care crisis, however the legal status of midwives has not been addressed as a partial solution. If the United States would follow in the footsteps of its European neighbors, where three-fourths of births are attended by midwives in some fashion, an average of \$8.5 billion might be saved.¹⁰⁴ During 1993, an average c-section in the United States cost \$11,000, and an uncomplicated vaginal birth cost \$6,430.¹⁰⁵ Comparatively, the average cost of complete prenatal, intrapartum, and postpartum care by midwives using non-hospital centers or patients' homes was \$1,200.¹⁰⁶ The federal government currently grants limited reimbursement for nurse-midwifery services only through Medicaid¹⁰⁷ and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).¹⁰⁸ However, when the Health Care Finance Administration formed the rules for nurse-midwife reimbursement under Medicaid, the payment was set at only 65 percent of physician fees for deliveries under the same circumstances including the cost of hospital and necessary amenities. This payment schedule was crucial to nurse-midwives because private insurers tended to follow the standards set by

103. Rushing, *supra* note 14, at 57.

104. Hafner-Eaton & Pearce, *supra* note 2, at 831.

105. Margaret Mushinski, *Average Charges for Uncomplicated Cesarean and Vaginal Deliveries*, STATISTICAL BULLETIN—METROPOLITAN LIFE INSURANCE COMPANY, Oct. 1994, at 27.

106. L. Wayne Hicks, *State Plans to Deliver Opinion on Licensing of Lay Midwives*, DENV. BUS. J., Mar. 1, 1991, available in LEXIS, Regnws Library, Arcnws File.

107. See 42 U.S.C. § 1396d(a)(17) (1982).

108. See 10 U.S.C.A. § 1079(a)(13) (West, Supp. 1985), permitting reimbursement for midwifery services utilized by dependents of members of the uniform services.

Medicaid. In order to be reimbursed for their services, nurse-midwives must follow the same standards of practice as obstetricians and gynecologists, who are paid more and have identical practice overhead costs. Lower reimbursements have served as a disincentive for physicians, hospitals, and health services to employ nurse-midwives. However, insisting that nurse-midwives follow the same standards of practice as physicians compromises the cost-effectiveness of nurse-midwife care. They are forced to use biomedical procedures which are both costly and contrary to a noninterventionist philosophy.

Given the current universal concern over the escalating cost of health care, as well as President Clinton's support for the independent status of midwives during his tenure as governor of Arkansas, it seemed likely that home birth would play a significant role in health care reform. Within the context of the Clinton administration's focus on reduction of expenditure, childbearing clinics and home-centered births would provide a model for controlling growing health care costs while improving the quality and access of care. The introduction of proper prenatal care by midwives to low-income families could alone decrease the incidence of low-birth-weight babies and ultimately lower the infant mortality rate, while at once curbing the cost of such care. Unfortunately however, the language declaring the independent provider status for midwives which was a part of the Clinton administration's original Health Securities Act description was dropped when that Act was filed.

VII. CONCLUSION

United States and Canadian experts maintain the prediction that midwifery will be the trend of the future in health care. However, currently many physicians continue to successfully thrust their anxieties about the future of their medical practice upon the legislatures. Often the restrictive laws were enacted by legislatures who "act[ed] on advice given by medical personnel, believ[ing] their enactment of restrictive childbirth attendant law to be for the public good."¹⁰⁹ However, if the legislatures were to look beyond the "image" of sound medical advice it would be apparent that the medical profession actually

109. Kathleen M. Whitby, *Lay Midwives*, 30 ST. LOUIS U. L.J. 985, 997 (1986).

perceives . . . midwifery practice as a threat because it serves the needs of a growing number of health care consumers . . . [who] are unwilling to accept impersonal hospital policies and modern medical procedures that fail to provide emotional support to prospective parents and that emphasize unnecessary medical intervention.¹¹⁰

Until more states and provinces recognize this demand for midwife-autonomy, the current practice of birth-assistance will continue to reflect physician-shaped law.

Legislatures in both the United States and the provinces of Canada should recognize the need for, as well as the practicality of, the midwifery profession. These legislatures need to comprehensively recognize both nurse-midwives and lay-midwives as professionals by law, with the autonomous status necessary to provide care independent of physicians. Where equivalent care is possible from either a physician or a midwife, the freedom to choose a provider and a location for birth should be recognized by statute. Thus the United Kingdom's regulatory boards, which enable the midwives themselves to regulate, certify, and discipline their profession, provide an effective model to our legislatures.

In the United States, the trend is beginning to take hold in some states. The employment of nurse-midwife assistants has increased ten-fold in the past twenty years. In 1975 only about 25,000 births were attended by nurse-midwives in urban hospitals, while in 1995 more than 200,000 babies were delivered by nurse-midwives.¹¹¹ Due to the shortage of obstetricians who are able to finance the high cost of malpractice insurance in Florida, the state now recommends nurse-midwives assist at fifty percent of low-risk births.¹¹² In a few states, such as Texas, anyone can legally deliver a baby. Recently New Mexico and Alaska have allowed testing and licensing of lay midwives. Additionally, New York, cognizant of its growing need for low-income health care, has planned for recognition laws as well as training programs for lay midwives.¹¹³

110. McCormick, *supra* note 31, at 672.

111. Edwin W. Brown, *An Ancient and Honorable Profession in the Modern World: Midwives*, MED. EDUC. AND RESEARCH FOUND. MED. UPDATE, June 1994, at 4.

112. Cunningham, *supra* note 45, at 105.

113. Campbell, *supra* note 61, at 114.

The examples set by a limited number of states and by the countries of the European Union must be followed. The need for international recognition of midwives outweighs any competing financial interests of physicians. The European Union has shown the practicality and safety of midwifery as a profession, with or without a uniform health care system and regardless of the place of birth which a mother chooses. The world should learn from these countries in which not only are babies healthy and normal, but their mothers emerge from the birth process unscarred and emotionally fulfilled.